ANOKA STATE HOSPITAL

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Chief Executive Officer

ANOKA STATE HOSPITAL

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I. Executive Summary

The Anoka State Hospital is the foundation of the mental health/chemical dependency service system which serves the Twin Cities Metro Area.

Because of its small size relative to the large population it serves, only the most severely mentally ill and chemically dependent people in the area obtain its services, usually through the commitment process for the mentally ill and disabled.

The hospital also accepts the medically indigent person and the person who requires longer hospitalization than private insurance will pay. Cuts in and restrictions of public and private hospital insurance are believed to be a major reason for an 18% increase in admissions during the past year.

The hospital's patient-care buildings meet all licensure requirements. With the inclusion of an automatic emergency electrical generator in the State bond sale on August 4, 1982, the hospital will meet all requirements for full federal Medicare certification.

The hospital's professional staff is fully credentialed and licensed and includes four full-time board certified or eligible psychiatrists, licensed consulting psychologists, professional social workers, professional registered nurses, and a wide variety of other high-level professional mental health and supportive workers.

The hospital's organization plan and programs are flexible and responsive to the changing needs of the community for specialized services.

The hospital is actively guided by a Community Board for Policy, Planning, and Liaison, which represents the counties and local communities, and it is working in contact with other providers of services, patient advocacy groups, mental health associations, and many others to continuously improve its effectiveness and efficiency, and to determine the potential for regional and local organizational changes to benefit the public.

II. Statement of Purpose

PURPOSE OF THE ANOKA STATE HOSPITAL:

The purpose of the Anoka State Hospital is to provide psychiatric and mental health treatment services and chemical dependency treatment services to residents of the five county metropolitan area who require a relatively more protective residential environment for relatively longer periods of time than are available through local treatment providers: the Anoka State Hospital may provide primary local mental health services for its immediate community with proper authorization and funding. Services are available to all people without restriction with regard to inability to pay.

PURPOSE OF THE CLINICAL TREATMENT PROGRAMS:

The purpose of the clinical treatment programs is to rapidly reduce symptoms of psychosis and other severe impairment so that further treatment can be implemented which will ensure the safety of the patient and others in the community. Clinical treatment programs on campus can be cost effective only when there are linkages—both programmatic and fiscal—with regional public and private services to assure continuity of care and active aftercare within the patient's community.

RELATIONSHIPS WITH EDUCATIONAL INSTITUTIONS:

It is recognized that clinical services are enhanced by both research and educational involvement. Linkages will be developed with the University of Minnesota and other institutions to ensure student training opportunities in all disciplines at both graduate and postgraduate levels and to enrich our ongoing research and evaluation efforts.

HUMAN RESOURCES:

The human resources requirements of the hospital will be developed to ensure that the care, safety, and treatment needs of the patients and that the management needs of the hospital are adequately and competently staffed.

COMMUNITY RELATIONS/COMMUNICATIONS:

The safety, security, and service requirements of the community surrounding the hospital will be addressed in all hospital programs and an active program of public information and involvement in hospital programs will be maintained.

ORGANIZATION AND ADMINISTRATION:

The planning, organizing, fiscal support and management of the hospital program by the Governing Board and Hospital Administration, guided by the Community Planning, Liaison and Advisory Board, will maximize the allocation and utilization of resources and development of systems to ensure that all performance standards and regulatory requirements are met.

HOSPITAL ENVIRONMENT:

The hospital's campus, buildings and grounds, and equipment will be maintained and developed to adequately support the above goals and to meet licensure, accreditation and all other regulatory and professional standards. In addition, the hospital will strive to achieve a physical appearance throughout its residential, administrative, and public areas which symbolizes the respect to which the patients and staff of the hospital and the citizens of the State of Minnesota are entitled.

III. The State Hospital as the Foundation of the Mental Health System and the Difference of this Role and Resources Available by Area of the State

Recent studies (see "The Enduring Asylum" (1981), and "The Multiple Functions of the State Mental Hospital" forthcoming in the American Journal of Psychiatry) provide compelling and startling information about the social usefulness of the public mental hospital and its universal presence throughOut the Western World.

With reference to the United States, Morrissey and Goldman (1981) indicate that "state mental hospitals continue to serve their historic patient care and social control functions, albeit at a reduced level. Data available from the National Institute of Mental Health (Goldman & Rosenstein, 1979) indicate that: 1. These hospitals still serve a substantial acute care function. In 197 5 approximately 400,000 admissions (duplicated count), consisting largely of persons from socially and economically disadvantaged background, were recorded by the 313 state and county mental hospitals in the United States. 2. These hospitals still serve a major social control function through civil, criminal, and emergency commitment. In 1972, some 200,000 persons were admitted to these hospitals on involuntary status. 3. These hospitals still serve a sizeable custodial care function. At present, there are some 100,000 to 125,000 resident patients in state hospitals who cannot be moved permanently into community facilities, either because they are 'inappropriate' (too disturbed or too disturbing) for current types of residential alternatives or because the alternatives are not available."

This information suggests that the Anoka State Hospital is a remarkable hospital in a remarkable mental health system because the rate of admissions for mental illness and chemical dependency from the Metro area (including those CD admissions at Moose Lake State Hospital) is less than one-half the rate of admissions nationwide as indicated above (utilizing populations of 220,000,000 for the nation and 2,200,000 for the Metro area).

This fact suggests that there has been the development and maintenance of a relatively effective community-based mental health treatment and support system: and it partially explains how the Metro area has been able to be supported by a small number of State Hospital beds at Anoka State Hospital (1.5 State Hospital beds per 10,000 Metro area residents).

The outstate public hospitals apparently require far more beds because of the unavailability of psychiatric beds in the community hospitals. For example, Willmar State Hospital serves a population of almost 600,000 with 333 MI beds, a ratio of .55 beds per 1,000 population. Anoka State Hospital serves a population of approximately 2,200,000 with 252 MI beds, a ratio of .11 beds per 1,000 population.

To dramatize this comparison further, let us assume that the following state hospital beds are utilized exclusively for the Metro area:

Anoka State Hospital - all useable beds	342
Moose Lake State Hospital - Ramsey County CD beds	89
Minnesota Security Hospital - all beds	236
Cambridge State Developmental Center	550
Total State Facility "Metro" Beds	1217

This construct provides the Metro area with a rate of .55 beds per 1,000 population to serve all three disability groups.

Another example: following the closure of Rochester State Hospital, the St. Peter State Hospital MI bed complement for its catchment area population (143/708,575) provides an available bed rate of .20 per 1,000 population, nearly double the beds available to the Metro area at Anoka State Hospital.

These differences in the allocation of State Hospital resources to different areas of the State must lead to inquiries about the treatment systems within which the hospitals operate, their own functions as an expression of those systems, understandings of their differences, and reconciliation of serious inequities where they are discovered.

Anoka State Hospital backs up a service system which can include hundreds of private hospital psychiatric beds if they are paid for with public funds (Medicaid/GAMC/Block Grants/Purchase of Service Contracts).

Yet Anoka State Hospital must usually reserve its beds for committed patients, turn away voluntary patients, work aggressively to find discharge facilities, and strive to shorten hospital stays to provide more admission capability. The hospital's admission criteria emphasize admission of people who meet the criteria for commitment.

Despite this apparent bed unavailability MI admissions have increased 17.7% from FY 31 to FY 32, placing great stress on the hospital's ability to operate safely. Similarly, Hennepin County Medical Center reported an increase in psychiatric admissions of 18Z from September 1980 to September 1981 (W. Jepson, M.D., Chief of Psychiatry, 1/25/82, memorandum).

We believe that the legislated authorizations to cut GAMC to community hospitals to payments below their found costs have forced these hospitals to deny admission to the psychiatric medically indigent and force them into the County and State hospitals serving the Metro area.

If this is true, the system has been adjusted downwards in one way and will have to be adjusted upwards (more State Hospital beds and staff) to compensate.

At the other end of our system, aftercare and treatment follow-up and housing and employment/school/day facilities for Anoka State Hospital patients who might be discharged, there is a chronic shortage of resources.

We believe this is true because of the emergence of new populations of chronically mentally disabled people who are Just coming to our attention. This group of young adult chronic patients are absorbing the resources of the community as they become available.

What future additional and unanticipated mentally ill population groups will emerge? How will we be flexibly prepared to address their needs and the problems they offer the community? For example, the swelling of the ranks

of older people in the future is known: is there likely to be a significantly larger absolute and proportional number of older people who have severe psychiatric and behavioral disabilities?

The State Hospital is the constant back up system and foundation, the presence and availability of which makes possible the concurrent organization of possible alternative programs.

In the Metro area, the relatively and absolutely small size of the Anoka State Hospital requires that it serve only the most severely disabled mentally ill and chemically dependent people at those recurrent times when they require longer term hospital services than are available in the community. For these people, at these times, Anoka State Hospital is the most beneficial alternative.

IV. The Patient Service Role of the Anoka State Hospital

Anoka State Hospital has a wide variety of role functions in serving the various specialized mental illness and chemical dependency treatment requirements of patients, and concomitantly meeting the needs and expectations of families, counties, courts, other treatment facilities, and communities. These requirements, needs, and expectations are often in conflict among themselves. The fundamental conflict is between the community's desire for public safety (including the patient's safety) and the individual's desire to be left alone as a free agent regardless of severity of functional disability. The processes for resolving these conflicts include negotiation among the parties involved and implementation of the Minnesota Hospitalization and Commitment: Act, an adversarial process involving legal representation of the parties with decision-making by the District Courts.

Anoka State Hospital therefore serves a public health and safety role which begins when a patient is committed by the District Courts or is admitted, pursuant to other rules, against his will. 82% of the Mental Illness Treatment Program patients at Anoka State Hospital on June 30, 1982 (187 people) are committed; 14% of the Chemical Dependency Treatment Program patients (11 people) are committed.

A second group of patients are those who seek hospitalization at Anoka State Hospital on a voluntary or "informal status" basis. This usually results from a series of community treatment experiences and short-term hospitalizations, together with an exhaustion of hospital Insurance benefits, which have not improved the patient's functional ability sufficiently, and longer term State hospital-baaed treatment is determined to be the most effective and least expensive (to the family/county) resource. Frequently the voluntary status patient is induced in a variety of ways to seek this hospitalization to avoid less pleasant alternatives. 18% of Mental Illness Program patients (41 people) and 86% of Chemical Dependency Treatment patients (67 people) are on informal/voluntary status.

A third group of people served by the Anoka State Hospital are those who essentially live at the hospital as permanent residents. There are approximately 44 people who range in age from the late twenties to the early 60s who are not physically disabled, who do have psychiatric diagnoses, and who have functional behavioral disabilities which have resisted a wide variety of treatment modalities over an extended hospitalization period. Most of these people do not have a family or community to relate to and are believed to be dependent upon the state hospital for all life supports. These people are talked about as "career" psychiatric hospital patients.

A fourth group of people served by the hospital are those who are relatively older (median age 58) and who suffer from physical disabilities and frailness in addition to psychiatric illness and behavior deficits. These people are served in our psychogeriatrics unit: there are 37 people in this group. Generally these people present management problems and risks which nursing homes cannot or do not wish to work with.

A fifth group of people served are a relatively new and emerging population, the multiple-disabled with mental illness and chemical dependency problems. These are people who are relatively young (median age 24 at Anoka State Hospital), predominantly male (77%), and strongly resistant to both mental illness and chemical dependency treatment modalities. The hospital organized a special treatment program to serve these people in January, 1981. The MI/CD program currently serves 39 people.

A sixth group of people are those who require hospital-based services for periods of up to six months for stabilization and rehabilitation after recurring psychotic episodes in the community. Our objective is to assist them to return to community residence.

A seventh group of people are those whose disability is habitual substance abuse and chemical dependency. Anoka's program and resources are inadequate to meet the demand for service from the entire Metro Region. Moose Lake State Hospital serves Ramsey and Washington Counties; Anoka serves Hennepin, Anoka, Dakota and Sherburne Counties. We currently serve 41 people in our Primary program and 30 in our extended program.

An eighth group of people served by the hospital are those who have been determined to be mentally ill and dangerous by the courts. Anoka's role with these people is primarily to serve as the transitional treatment facility between the Minnesota Security Hospital in St. Peter and eventual return to residence in the Metro Region. The hospital is also responsible for sharing responsibility with the county of residence in monitoring these people after discharge from the hospital. There are 12 people in this group in residence at the hospital and 10 being monitored post-discharge.

A ninth category of people served by the hospital are those with unique multiple problems for which the private and county service systems hare not been successful in developing specialized assessment, evaluation, treatment, and supportive programs. The hospital has no special resources or ability to provide the necessary programs either. However, these people are committed to the hospital by the courts until a more appropriate program can be located or developed. Examples are: a mentally ill/possibly mentally retarded Laotian female teenager with no English language ability; a deaf 20 year old young man with retarded social development and assaultive behavior.

A. MENTAL ILLNESS TREATMENT SERVICES:

Program Title	Location	Description	Unit Director
Admissions Unit 27 beds	Miller North	Secured intake, assessment, evaluation, short— term treatment, early discharge, and referral unit.	M. Hanson, R.N. W. Routt, M.D., Psychiatrist
Secure Intensive Care Unit 23 beds	Miller South	Secured intensive care; short-term services for patients with other primary assignments; who are dangerous to themselves or others.	D. Root, R.N. F. Ferron, M.D. Psychiatrist
MI/CD Unit 45 beds	Vail I	Specialized treatment program for mentally ill people with concomitant chemical dependency problems.	M. Cooper, M.S., Psychologist R. Baumer, M.D. Psychiatrist
Social Skills Unit 48 beds	Vail II	Long-term chronically ill patients. Emphasis on A.D.L., group work, goal setting, pre-vocational training.	R. Flenniken, M.S. Psychologist K. Fox, M.D. Psychiatrist
Gero-Psychiatric Unit 36 beds	Vail III	Infirm, elderly psychiatric patients, patients with concomitant medical management problems; patients being prepared for transfer to SNF's.	K. Tuneberg, R.N. M. Peper, M.D. Psychiatrist
Behavior Modification Unit 37 beds	Cottage 9	Program for people with specific behavior problems which prevent their participation in other therapeutic programs (Example: Chemical Dependency Treatment Program),	K. Peterson, R.N. S. Hwang, M.D. Psychiatrist
Step Level, Fairweather Unit 37 beds	Cottage 8	An extension of short-term step level treatment for patients from the Admissions Unit who can be prepared for discharge within 3 to 6 months either to a Fairweather Lodge or other community placement.	M. Buskirk, R.N. , M.S. K. Fox, M.D. Psychiatrist

ANOKA STATE HOSPITAL - TREATMENT UNIT PROFILES (continued)

B. CHEMICAL DEPENDENCY TREATMENT SERVICES:

Program Title	Location	Description	Unit Director
Primary Care Unit	Cronin Bldg., Main Floor	Intensive 35-45 day program for adults with problems of chemical abuse/dependency.	Bruce Olson, M.S.W. P. Arcedo, M.D.
Extended Care Unit	Cronin Bldg., Upper Floor	Extended 3-6 month treatment program for chronic chemically dependent adults with pattern of recidivism.	Bruce Olson, M.S.W. P. Arcedo, M.D.
Family Program (Outpatient)	Cronin Bldg., Lower Level	Structured outpatient program (4-5 sessions) for relatives or friends of patients who are being treated in CDC.	John Hurley, M.S.W.
Aftercare Program (Outpatient)	Cronin Bldg., Lower Level	Weekly outpatient support groups for alumni of inpatient or family programs	John Hurley, M.S.W.

A tenth category of people are those believed to be mentally ill by the courts but who are subsequently determined by the hospital to be clear of mental illness but who do exhibit severe character disorders, social malfunction and disfunction and similar problems. Behavior is characteristically assaultive, abusive, destructive, and manipulative. These people have had frequent contact with the police and courts. They similarly prey upon other vulnerable patients, staff, and community when at the hospital. The hospital's objective is to return these people to the courts with findings and recommendations of appropriate alternative planning.

V. The Anoka State Hospital Role in Education and Training

The Anoka State Hospital utilizes a wide variety of technical specialties in its administrative, clinical, and support services functions. The patients include the most severely disabled mentally ill and chemically dependent people in the Metro Region who are served, also, at varying stages of their disabilities, by the private treatment sector and the University Hospitals, and the counties through aftercare (outpatient) and supportive programs.

These factors, considered together, have been recognized to provide *a* wide and rich opportunity for educational and training programs to provide staff and students who are working or wish to work in the fields of mental illness, mental health, chemical dependency, and all the specific associated technical fields with practical and unique educational experiences. Formal programs include:

1. With the University of Minnesota:

    a. Mental health and hospital administration
    b. Psychiatry
    c. Medicine
    d. Nursing
    e. Psychology
    f. Recreation Therapy
    g. Pharmacy and psychopharmacology
    h. Dentistry for the mentally disabled
    i. Chemical dependency counseling

    A major achievement of these programs was the completion by a senior resident physician in psychiatry of a full nine-month rotation at Anoka State Hospital, resulting in his full-time employment as a Board-Eligible psychiatrist at the hospital following his graduation.

    A second major achievement has been the establishment of a special dental reside at training program to equip dentists to work with the mentally disabled and encourage them to seek employment with the State. By June 30, 1983 we will have trained one second year resident in Hospital Administrative Dentistry, and five first-year residents in clinical practice.

In addition, a number of Anoka State Hospital staff have received University of Minnesota faculty appointments, including the Chief Executive Officer and the Medical Director.

2. Other College and University Affiliations:

a. Nursing - Metropolitan State University
b. Psychology - Anoka Vocational Technical School
c. Landscaping - Anoka Vocational Technical School
d. Licensed Practical Nursing - Anoka Vocational Technical School
e. Human Services Technician - Anoka Vocational Technical School
f. Chemical Dependency Counseling - St. Mary's Junior College
Metropolitan State University
Minneapolis Community College
g. Clinical Chaplaincy - Luther Northwestern Theological Seminary
h. Mental Health Lav - Hamline University Law School
William Mitchell College of Law (proposed)
i. Social Worker - State University of North Dakota

3. Secondary School Work/Study Program:

Terminated during the past two years because of the budget cuts, the hospital's financial reorganization plan will provide for the employment and training of senior high school students in psychiatric technician and nursing skills in coordination with the senior high schools in Anoka, Blaine, and Coon Rapids.

A. Joint Ventures in Education and Training:

The Anoka State Hospital seeks out opportunities of mutual benefit with organizations of all types. A recent example is the affiliation with Minnesota Outward Bound Programs. Ten Outward Bound staffers spent a week in study at Anoka State Hospital learning skills in working with the mentally disabled and chemically dependent. The Anoka State Hospital staffers spent a week in study at Outward Bound learning new activity program concepts and skills to bring back to Anoka State Hospital, and conducted in-service training for the rest of the hospital staff.

VI. The Anoka State Hospital Role in Community Mental Health Education

The hospital has organized an active group of Mental Health Players to provide dramatic presentations of mental health issues and information to community groups at their request. Since the fall of 1980 the Mental Health Players have performed for 89 groups reaching over 3,951 people. Presentations have been made to:

1. School health classes
2. Community hospitals
3. Church groups
4. Parents without partners groups
5. County social workers

6. Social clubs
7. Service clubs
8. Professional clubs (business women, etc.) and many others

In addition, hospital staff have discussed mental health issues with many other community organizations including Kiwanis, Rotary, Chamber of Commerce, League of Women Voters, Mental Health Associations, etc.

VII. The Anoka State Hospital Role as Employer

Anoka State Hospital currently employs 359 people whose counties of residence are:

County	Worker	*Approximate Payroll
Anoka County	240	$ 5,115,792
Hennepin County	69	1,470,790
Ramsey County	29	618,158
Sherburne County	12	255,790
Isanti County	4	85,263
Washington County	5	106,580
TOTALS	359	$ 7,652,373

*Payroll includes base salary, fringe benefits, overtime, shift differential, and other additions to salary.

VIII. The Anoka State Hospital Role as Purchaser of Services

During fiscal year 1982 (7/1/81 - 6/30/82) Anoka State Hospital purchased $472,778.00 of goods and services in Anoka County. The largest accounts were with North Central Public Service ($237,647.79), City of Anoka ($126,639.26) and with Mercy Medical Center ($75,578.56).

IX. The Anoka State Hospital Role as Conservator of Public Assets

Anoka State Hospital occupies 244 acres along the eastern shore of the Rum River in the City of Anoka. Directly to the north is the Anoka Senior High School and City park land; the west bank of the Rum River directly facing the hospital campus is Anoka County park land. A significant portion of this valuable wetland and its adjoining areas are therefore maintained for public use.

X. Resources of the Anoka State Hospital

A. Expenditures Report - Fiscal Year 1982 (7/1/81 - 6/30/82):

ANOKA STATE HOSPITAL
Summary of Expenditures for
Fiscal Year 1982
(7/1/81 - 6/30/82)

EXPENDITURE CLASS	LIQUIDATIONS
Salaries	$7,652,373.38
Workers Compensation	216,965.14
Unemployment Compensation	46,140.78
Contractual Services	360,349.00
Patient Pay (Industrial Therapy)	167,140.36
Food	272,829.98
Fuel and Utilities	439,119.00
Special Equipment	20,393.52
Repairs and Betterments	48,876.42
Drugs/Medical Supplies	138,830.00
Patient Personal Needs Allowance	5,810.18
"All Other" (includes all hospital program supplies and expenses not included above)	149,691.82
TOTAL	$9,518,519.58

(Expressed to include 3rd and 4th quarter workers and unemployment
compensation obligation.)

B. Review of staffing by function, authorization, and funding:

ANOKA STATE HOSPITAL STAFF

Administrative-Supervisory-Support

Chief Executive Officer	1	Cook	2
Accounting Supv. Inter	1	Cook Supervisor	5
Account Clerk	2	Delivery Van Driver	6
Accounting Technician	1	Dictaphone Operator	3
Asst. Administrator	1	Dietician	2
Bldg. Maint. Supv.	1	Food Service Worker	13
Business Manager		Stationary Engineer	5
Chief Engineer	1	Stares Clerk	2
Inst. Program Coord.	2	Switchboard Operator	4
Personnel Director	1	General Repair Worker	2
Physical Plant Director	1	Groundskeeper	1

Management Analyst Inter	1	Inst. Training Supv.	1
Bldg. Services Lead	1	Janitor	11
Typing Pool Supervisor	1	Laborer	1
Auto Mechanic	1	Laundry Assistant	1
Baker	2	Librarian	1
Barber	1	Mason	1
Carpenter	2	Mechanical Stock Clk	1
Chief Cook	2	Fainter	2
Clerk 2	1	Personnel Aide	2
Clerk 4	1	Plant Maint. Engineer	4
Clerk Steno	2	Service Worker	7
Clerk Typist 4	2	Sewing Machine Oper.	1
Clerk Typist 2	3	Special Teacher	2

TOTAL 113

Professional-Technical Behavioral Analyst	4	Hospital Service Spec.	12
Chaplain	2	Pharmacist	2
Chemical Depend. Couns.	7	Pharmacist Technician	1
Dentist	1	Psychologist	6
Reg. Dentist Assist.	1	Radiologic Technician	2
Director of Nurses	1	Social Worker	18
Group Supervisors	6	Medical Director	1
Rehab. Therapist	3	Staff Physician	7
Recreational Therapist	7	Psychiatrist	3
		General Practitioner	4

TOTAL 81

Nursing-Residential

Human Service Technician	71
Hospital Service Assist.	7
Licensed Practical Nurse	44
Registered Nurse	40

TOTAL 162

TOTAL 356

XI. Impact of the LOBS of the Anoka State Hospital

A. Introduction - Experience of Partial Closure:

A significant portion of the resources of the Anoka State Hospital have already been lost to the Metro area through the reduction of available beds in both the HI and CD programs.

During FY 81, Cottage 2, Cottage 4, and the "Nurses Dorm" were taken out of use because of lack of code compliance. Approximately 48 HI beds and 43 CD beds were lost after adjusting for the new CD building, *A 20%* reduction.

Five additional HI beds have been taken out of use to provide a safer ratio of staff to patients on specific treatment units and to provide some essential programming space.

The resulting "mean and lean" hospital complex with fever beds has resulted in the following problems as expressed by the counties and courts.

1. Unavailability of adequate beds to admit voluntary/informal patients who do meet criteria for admission. In FT 82 approximately 75 people in this category did not gain admission when requested.

2. Complaints from Hennepin County, in particular, that the con comitant commitment process costs cannot be avoided because this is the chief method of obtaining an Anoka State Hospital bed.

3. The frequent development of waiting lists for CD program admission.

4. The diversion of some CD patients to other state hospitals (such as Fergus Falls State Hospital).

5. Increased tension with county staff applied by Anoka State Hospital staff pushing aggressively for patient discharge arrangements in the community.

6. Requests from Ramsey County to:

   a. Establish an additional MI unit to provide transitional services.
   b. To provide CD services (in lieu of Moose Lake State Hospital) to avoid transportation costs.

7. Requests from Tasks Unlimited to provide additional transitional units on campus to expand the capability of the Fairweather Lodge Programs to meet the needs of its waiting lists of patients.

8. Evidence that 51% of MI admissions have had previous Anoka State Hospital admissions. This fact is not indicative of anything clear at this point, but does indicate a need for a very careful research inquiry into the question of recidivism in the Metro area, and Anoka State Hospital/mental health system program implications.

9. Startlingly higher admission rates to Anoka State Hospital (17.7%) and the county psychiatric inpatients units during the past year.

10. Evidence of severe illness and disability: of the 508 MI admissions in FY 82, 320 (63%) had documented evidence of threatening/ assaultive behavior; 331 (65%) documented history of drug use/ abuse; 177 (35%) documented history of suicidal ideation or behavior. This documentation was made available to the hospital at the time of admission by referral sources.

B. Population Served:

The following page provides recent data with regard to catchment area population by program (MI 1,943,785) (CD 1,368,685) (the Metropolitan Council is projecting a 20% increase in the population of the Metro area by the year 2000); census by program by county in the hospital, rate of census by county by program, number of admissions by county, and rate of admissions by county.

The rates are probably the most useful statistics (according to demographers and epidemiologists) for making comparisons and drawing conclusions.

1. The three largest counties utilize the MI program at about the same rate.

2. Sherburne and Anoka utilize CD significantly more than does Hennepin.

3. Dakota and Washington have very low utilization rates - do their disabled and severely ill people migrate to the Cities?

4. Ramsey CD patients at Moose Lake State Hospital included 596 admissions in FY 81 (Moose Lake State Hospital Impact Report) for a rate of admission similar to Sherburne County's, but two and one-half times greater than Hennepin County's.

C. Population Characteristics Profile:

Please see the following pages.

UTILIZATION OF ANOKA STATE HOSPITAL, AND ITS PROGRAMS, BY CATCHMENT AREA COUNTIES

ANOKA STATE HOSPITAL MEDICAL RECORDS DATA FOR 1/82-3/82 ANNUALIZED

COUNTY	1981 Pop. Est. for County	No. Census Pts./Co. March 31, 1982			No. Pts./10,000 Pop. of County			No. Admissions/Co. Annualized			No. Adms./10,000 Pop. of County Annualized		
		MI	CD	Total	MI	CD	Total	MI	CD	Total	MI	CD	Total
ANOKA	198,520	22	19	41	1.11	.96	2.07	48	200	248	3.24	10.08	13.32
DAKOTA	197,640	6	4	10	.30	.20	.51	28	32	60	1.4	1.6	3.0
HENNEPIN	941,130	137	59	196	1.46	.63	2.08	296	472	768	3.16	5.0	8.16
RAMSEY	459,560	62	-	62	1.35	-	1.35	140	-	140	3.04	-	3.04
SHERBURNE	31,395	2	4	6	.64	1.27	1.91	4	40	44	1.28	12.76	14.04
WASHINGTON	115,540	2	-	2	.17	-	.17	4	-	4	.36	-	.36
CATCHMENT AREA TOTALS MI	1,943,785	231			1.18			536			2.76		
CATCHMENT AREA TOTALS CD	1,368,685		86	317		.63			744	1,280		5.44	10.96

Ramsey and Washington Counties are not included in the Chemical Dependency Treatment Program's catchment area.

ANOKA STATE HOSPITAL

June 30, 1982

UNIT/PROGRAM END OF QUARTER CENSUS SUMMARY

		V 1	V 2	V 3	C 8	C 9	M S	M N	MI	PTU	ETU	CD	TOTAL
	N =	39	42	37	34	36	21	23	232	41	30	71	303
SEX	Male	30 77%	24 57%	21 57%	20 59%	20 56%	13 62%	12 52%	140 60%	34 83%	25 83%	59 83%	199 66%
	Female	9 23%	18 43%	16 43%	14 41%	16 44%	8 38%	11 48%	92 40%	7 17%	5 17%	12 17%	104 34%
RACE	White	31 79%	39 93%	35 95%	32 94%	31 86%	19 90%	18 78%	205 88%	37 90%	25 83%	62 87%	267 88%
	Black	5 13%	3 7%	2 5%	2 6%	1 3%	2 10%	3 13%	18 8%	3 7%	2 7%	5 7%	23 8%
	American Indian	2 5%				3 8%		2 9%	7 3%	1 2%	3 10%	4 6%	11 4%
	Hispanic												
	SE Asian	1 3%				1 3%			2 1%				2 1%
	Other												
MARITAL STATUS	Single	37 95%	27 64%	23 62%	30 88%	30 83%	18 86%	16 70%	181 78%	27 66%	9 30%	36 51%	217 72%
	Married		5 12%	5 14%	2 6%		1 5%	2 9%	15 6%	3 7%	5 17%	8 11%	23 8%
	Separated			2 5%					2 1%	1 2%	2 7%	3 4%	5 2%
	Divorced	2 5%	8 19%	1 3%	2 6%	6 17%	2 9%	3 13%	24 10%	10 24%	12 40%	22 31%	46 15%
	Widowed		1 2%	6 16%				1 4%	8 3%		2 7%	2 3%	10 3%
	Unknown		1 2%					1 4%	2 1%				2 1%

ANOKA STATE HOSPITAL
Unit/Program End of Quarter Census Summary (Continued)

		V 1	V 2	V 3	C 8	C 9	M S	M N	MI	PTU	ETU	CD	TOTAL
	N =	39	42	37	34	36	21	23	232	41	30	71	303
AGE	Median Age	24	34	58	30	28	30	31	31	30	44	34	32
CURRENT LEGAL STATUS	Informal	10 26%	3 7%	8 22%	10 29%	3 8%	1 5%	6 26%	41 18%	36 88%	25 83%	61 86%	102 34%
	Emer HO												
	C/PC-HO												
	CD-HO					1 3%			1 -				1 -
	C/PC-MI	19 49%	38 90%	27 73%	20 59%	28 78%	18 86%	15 65%	165 71%	1 2%		1 1%	166 55%
	C/PC-CD									4 10%	5 17%	9 13%	9 3%
	C/PC-MI&CD	10 26%				1 3%	1 5%	1 4%	13 6%				13 4%
	C/PC-MI&MD					2 6%			2 1%				2 1%
	C/PC-MI&D		1 3%	2 5%	3 9%	1 3%	1 5%	1 4%	9 4%				9 3%
	Other				1 3%				1 -				1 -

(Continued)

ANOKA STATE HOSPITAL
Census Summary (Continued)

(Continued)

COUNTY OF SETTLEMENT/ADMISSION			V 1	V 2	V 3	C 8	C 9	M S	M N	MI	PTU	ETU	CD	TOTAL
	N =		39	42	37	34	36	21	23	232	41	30	71	303
	Anoka	S	2 5%	4 10%	6 16%	2 6%	2 6%		1 4%	17 7%	9 22%	5 17%	14 20%	31 10%
		A	2 5%	3 7%	5 14%	2 6%	2 6%		2 9%	16 7%	9 22%	4 13%	13 18%	29 10%
	Dakota	S	2 5%			1 3%		2 10%	1 4%	6 3%	6 15%	3 10%	9 13%	15 5%
		A	2 5%			1 3%		2 10%	1 4%	6 3%	5 12%	3 10%	8 11%	14 5%
	Hennepin	S	25 64%	23 55%	21 57%	12 35%	24 67%	15 71%	16 70%	136 59%	24 58%	22 73%	46 65%	182 60%
		A	24 62%	21 50%	23 62%	15 44%	24 67%	16 76%	14 61%	137 59%	25 61%	22 73%	47 66%	184 61%
	Ramsey	S	10 26%	11 26%	8 22%	15 44%	6 17%	3 14%	4 17%	57 25%	1 2%		1 1%	58 19%
		A	11 28%	12 29%	6 16%	12 35%	6 17%	2 10%	4 17%	53 23%	1 2%		1 1%	54 18%
	Sherburne	S		1 2%		1 3%	1 3%			3 1%	1 2%		1 1%	4 1%
		A					1 3%			1 -	1 2%		1 1%	2 1%
	Washington	S		3 7%		1 3%	3 8%		1 4%	8 3%				8 3%
		A				1 3%	3 8%		1 4%	5 2%				5 2%
	Other	S			2 5%	2 6%		1 5%		5 2%				5 2%
		A		6 14%	3 8%	3 9%		1 5%	1 4%	14 6%		1 3%	1 1%	15 5%

ANOKA STATE HOSPITAL
Census Summary (Continued)

		V 1	V 2	V 3	C 8	C 9	M S	M N	MI	PTU	ETU	CD	Total
	N =	39	42	37	34	36	21	23	232	41	30	71	303
NUMBER PREVIOUS ASH ADMS	0	16 41%	15 36%	15 41%	16 47%	13 36%	14 67%	11 48%	100 43%	32 78%	18 60%	50 70%	150 50%
	1	13 33%	15 36%	11 30%	9 26%	11 31%	3 14%	5 22%	67 29%	6 15%	7 23%	13 18%	80 26%
	2	7 18%	6 14%	4 11%	5 15%	6 17%	3 14%	5 22%	36 16%		2 7%	2 3%	38 13%
	3	2 5%	1 2%	1 3%	3 9%		1 5%	2 9%	10 4%	2 5%	3 10%	5 7%	15 5%
	4	1 3%	2 5%	3 8%	1 3%	2 6%			9 4%	1 2%		1 1%	10 3%
	5			2 5%		1 3%			3 1%				3 1%
	6 +		3 7%	1 3%		3 8%			7 3%				7 2%
L of S*	Mean	400	1167	1632	378	663	739	32	767	20	48	32	-
	Median	58	485	373	133	266	96	12	139	13	46	21	-

*L of S = gross Length of Stay from date of admission, including Provisional Discharges and other absences from the hospital.

Percentage (%) may not total 100%.

Prepared by: Chuck Lucas
Management Analyst
July 28, 1982

1. Of particular note: the service population is typically young adult males with multiple disabilities and behavior management problems.

2. The MI program median length of stay has been declining steadily to its present level of 139 days through the very hard work of an excellent treatment/program staff.

Recent Change in MI Program Length of Stay

	Under 6 Months	Under 1 Year
October 1980	36%	49%
October 1981	46%	61%
April 1982	55%	65%

Another characteristic which deserves mentioning and further study is that studies of newly admitted patients indicate that as much as one-third of them may be original out-staters who have migrated to the Cities (as do many Minnesotans). However, it has been reported in the literature that the new young adult chronic mentally disabled population does migrate to the cities.

D. The hospital has staffed according to the difficult nature of the patients (88% are referred by hospitals, police, courts, etc.) with the highest level and largest number of fully-credentialed mental health treatment personnel available. These qualified psychiatrists, psychologists, professional nurses and social workers are not currently available at the other state hospitals to properly care for these severely disabled patients. The critical mass of these professionals necessary is only available in the Metro area, and probably in Rochester.

The first and foremost impact of closure of Anoka State Hospital therefore would be the likelihood that these people would simply not receive competent services anywhere else in the State.

E. Capacity Lost:

1. Ability of the rest of the state hospital system to absorb clients:

a. CD Program: It appears that it might be possible to absorb our 90-bed CD Program, which averages 83 patients, into the CD programs located at the Fergus Falls State Hospital and the Moose Lake State Hospital.

b. MI Program: It does not appear that the state hospital sys tem has sufficient excess bed capacity within its MI pro grams to absorb our average in-house patient population of 220. Over 500 annual admissions of the most severely ill people require availability of professional treatment currently unavailable outstate.

2. Other community resources available for various types of clients:

Approximately 80% of the referrals to our MX program are for individuals who hove obtained "maximum benefit" from a period of hospitalization of two weeks to three months in the community-based psychiatric inpatient facilities in our local hospitals which include the University Hospital, Hennepin County Medical Center, and St. Paul Ramsey Medical Center; the Vickerman Consent Decree has been utilized during the past year with regard to patients referred from Hennepin County to ensure that patients did not come to the Anoka State Hospital in the absence of all alternative resources being evaluated and utilized; admissions to the Anoka State Hospital during the past year are up 17.7% over the previous reporting period despite these aforementioned factors. It appears, therefore, that all other community resources are already being utilized for potential patients of the Anoka State Hospital which explains why the state hospital tertiary level mental illness and chemical dependency services would no longer be available to residents of the metropolitan areas within a reasonable distance. Additionally, community hospital psychiatry beds are apparently being used less because of GAMC rate cuts. This is bringing more medically indigent patients currently into public hospitals including Anoka State Hospital.

F. Impact on Clients:

1. Availability of treatment:

Approximately 90% of the patients of the Anoka State Hospital are no longer covered by hospitalization or health services insurances. The Anoka State Hospital provides services without restriction with regard to inability to pay. The availability of tertiary level services for the indigent population of the metropolitan area, in the absence of the Anoka State Hospital, is out of the question unless the private sector is paid public dollars for longer term care.

2. Distances involved:

Family participation, county social service participation, aftercare planning, etc., would be severely damaged by longer distances, most likely resulting in the conversion of out short-term patients to career state hospital patients.

3. Commitments:

With the filling of the available beds in the outstate hospitals by the patient population served by the Anoka State Hospital it is unlikely that beds for voluntary (informal) patients would be available at any state hospital. The consequence of this, therefore, would be the use by the counties of the commitment process to obtain state hospital placement for their residents.

4. Other:

We might anticipate that the closure of the Anoka State Hospital and the substitution of tertiary level services at the outstate hospitals would stimulate the various patient advocacy associations to consider bringing various actions against the State.

G. Impact on Counties:

1. Transportation:

Ramsey County has currently petitioned the Commissioner of the Department of Public Welfare to reassign it from the Moose Lake State Hospital chemical dependency catchment area to the Anoka State Hospital chemical dependency catchment area for two reasons, one of which includes their report that there is approximately ten to twelve thousand dollars of transportation costs to the county in bringing their patients to the Moose Lake State Hospital. We could guesstimate that transporting all the patients, both HI and CD, from the metropolitan area to the outstate hospitals would cost the Metro area counties at least $100,000 a year.

2. Participation in Planning Aftercare:

To quote from the February A, 1977 Hennepin County report, subject "Reaction to Governor Rudy Perpich's Budget Message to Close Anoka State Hospital", number 2, "The continuum of community care concept would be lost, and a true realization of deinstitutionalization would be most difficult to achieve."

3. Placement Problems:

These problems would be exacerbated to the extreme as a result of outstate hospital staff at a far distance from the county resources being unable to develop and maintain the continuous relationships and good will necessary to achieve effective patient placements. Also, pressure to establish new community services might decrease resulting in a public policy "fait accompli" to support large outstate hospitals as the mental health organizational policy of the future.

4. Commitments:

As indicated above, access to the state hospital system would most likely be entirely through the commitment process resulting in huge additional procedural administrative and legal costs to the counties. This is contrary to statutory policy which supports informal hospitalization.

5. Costs:

Costs should be looked at on at least three levels:

a. The cost to the individual recipient of services and his/her family could be expected to be the lost potential of receiving relatively rapid and effective assessment, evaluation, short-tens treatment, and return to community, home, school, job.

b. The cost to the counties, as indicated above, is likely to be extraordinary transportation costs, commitment process costs, etc.

c. The cost to the State, ultimately, sight be expected to be the necessity to have to plan to develop a facsimile of the Anoka State Hospital to resolve the problems created by its closure.

H. Impact on Staff;

1. Relocation and other costs:

It la unlikely that a large percentage of the Anoka State Hospital staff would choose to relocate to outstate hospitals in lieu of seeking employment elsewhere in the metropolitan system. We would not attempt, beyond that assertion, to estimate costs.

2. Unemployment:

The Anoka state Hospital staff is, as « rule, relatively highly skilled and highly employable. We would guesstimate that nearly the entire staff would be able to secure new employment within a period of six to eighteen months, depending upon general and health industry economic conditions.

I. Impact on Community:

1. Services no longer available:

The entire metropolitan area would lose access to the tertiary level psychiatric and chemical dependency treatment services available at the Anoka State Hospital. Anoka and Sherburne Counties would also lose the availability of the Anoka State Hospital to provide primary level mental illness and chemical dependency services which they require because of the unavail-ability of significant resources of this type within their boundaries.

2. State hospital payroll:

Approximately five million dollars of state hospital payroll would be lost to the immediate communities of Anoka, Coon Rapids, and Andover, Approximately an additional five million dollars would be lost to the remainder of the metropolitan area.

3. Estimated revenue lost to community:

Approximately five hundred thousand dollars of direct hospital expenditures in the local community would be lost in addition to the loss of the state hospital payroll.

XII. The Future Role of the Anoka State Hospital

The future of the Anoka State Hospital has been forecast by speakers at the recent Governor's Forum on Mental Health representing the Minnesota Mental Health Association and Project Overcome, who spoke about both the "precious resource" which the state hospital is for the severely mentally disabled and the necessity for the fundamental state hospital programs to become highly integrated and articulated with community-based programs which provide the remainder of the "continuum of care".

Other speakers stressed the necessity of distinguishing the "emotional troubles" which we all experience from time to time from severe mental disability, and to relate public policy priorities and funding appropriately.

Still another consideration is the very thoughtful work of Ted Kolderie, "Many Providers, Many Producers - A New View of the Public Service Industry" (Hubert H. Humphrey Institute of Public Affairs, University of Minnesota, April, 1982) which challenges the community to consider concepts of decentralization and distribution of the responsibility for the production of public services.

These concepts need to be considered by a Mental Health Authority for the Metro area for a single compelling reason: THE INCIDENCE AND PREVALENCE OF THE MOST SEVERE MENTAL DISABILITIES ARE SO LOW (1% to 2% of the total population) THAT THEY ARE NOT A HIGH PRIORITY OF THE GREATER POPULATION.

In a recent discussion, however, Paul Ellwood, M.D., Director of Interstudy, remarked that on the basis of a relatively high predictability of the incidence and prevalence of these severe disorders population-wide a public/-private insurance scheme might be developed. In theory, such an approach could move major expenditures into the private sector through insurance premiums and result in the inducement of many more competitive producers into the mental health system.

We will continue to work pro-actively to stimulate this type of thinking, and thinking together throughout the Metro area.

In the meantime, the Anoka State Hospital serves the Metro area and must be made to reflect the values and quality of the area in its service programs and facilities. These are only as good as the structural supports provided (knowledge, leadership, crucial physical plant and equipment, money, staffing and time).

We will continue to work very hard, simultaneously, at upgrading the effectiveness and efficiency of the hospital, encouraging the State Hospital

Planning Committee (Anoka State Hospital Community Board) to encourage the development of cooperative systems across jurisdictional boundaries, increasing the assets of the hospital to meet the demands of its clientele, and to participate in and influence public policy development.

We hope that all decision-makers will work equally hard on these issues on behalf of the public welfare.